



Lakeland Mental Health Center, Inc. Authorization for Release of Health Information

Client Information	Client Name: _____ LMHC# _____ Date of Birth: _____ Previous Name(s): _____ Address: _____ Phone: _____ City: _____ State: _____ Zip Code: _____ E-mail: (optional): _____	
I Authorize	Lakeland Mental Health Center (LMHC) To do the following: <input type="checkbox"/> Release To <input type="checkbox"/> Receive From <input type="checkbox"/> Both Release & Receive	<input type="checkbox"/> Fergus Falls, MN 56537 - 980 South Tower Rd – Tel: 218-736-6987 <input type="checkbox"/> Moorhead, MN 56560 – 1010 32 nd Ave South – Tel: 218-233-7524 <input type="checkbox"/> Alexandria, MN 56308 – 702 34 th Ave East – Tel: 320-762-2400 <input type="checkbox"/> Detroit Lakes, MN 56501 – 928 8 th Street SE – Tel: 218-847-1676 <input type="checkbox"/> Glenwood, MN 56334 – 14 6 th Ave NW – Tel: 320-634-3446
With	Agency/Name: _____ Relationship: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip Code: _____ Phone number: _____ E-mail (optional): _____	
What do you want released?	<input type="checkbox"/> Record Dates between: _____ to _____ <input type="checkbox"/> Diagnosis <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Psychological Assessment & Testing <input type="checkbox"/> History of Trauma/Injury <input type="checkbox"/> Progress Notes <input type="checkbox"/> Medications <input type="checkbox"/> Lab Reports <input type="checkbox"/> Substance Use Info <input type="checkbox"/> Admit/Discharge Dates & Reports <input type="checkbox"/> Emergency Notification Info <input type="checkbox"/> Family Involvement Info <input type="checkbox"/> School Reports/IEP <input type="checkbox"/> Recommendations <input type="checkbox"/> Functional Assessment <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Verbal <input type="checkbox"/> Other _____	
Purpose of Release	<input type="checkbox"/> Diagnosis & Treatment <input type="checkbox"/> Coordination & Follow-up <input type="checkbox"/> Update Record <input type="checkbox"/> Referral <input type="checkbox"/> Education Purposes <input type="checkbox"/> CSP Participation <input type="checkbox"/> Legal <input type="checkbox"/> Personal/Client Request <input type="checkbox"/> Insurance Purposes <input type="checkbox"/> Emergency notification <input type="checkbox"/> On-Site Chart Review <input type="checkbox"/> Other _____	
Substance Use Disorder (SUD) Special Consent	Per Federal Rule 42 CFR, part 2 this section must be completed to release SUD records <input type="checkbox"/> SUD Comprehensive Assessment & Assessment Summary <input type="checkbox"/> SUD Discharge Summary <input type="checkbox"/> SUD Weekly Summary Notes <input type="checkbox"/> Other: _____	
Preferred Method	<input type="checkbox"/> Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Secure Fax _____ <input type="checkbox"/> Secure E-mail _____	
Authorization	This consent will end one year from the date of the signature below unless I indicate an earlier expiration date or event here: _____ Client Signature: _____ Date: ____/____/____ OR legally authorized representative's signature: _____ Date: ____/____/____ Representative's relation to client (parent, guardian, etc.) _____	

LMHC will not condition my treatment, payment, enrollment, or eligibility for benefits by signing this authorization. I authorize LMHC to disclose the above stated records to the Name/Organization listed above. I understand this may include information regarding mental health, alcohol/drug use, and HIV records unless initialed below. I do not need to sign this authorization to receive services unless the services are court ordered or are being created solely for a third party. This consent will expire upon fulfillment of its stated purpose or one year from date of signature. I understand that I may revoke this consent by written notice at any time except (1) when legal action prevents revocation (probation, parole, court confinement), or (2) when requested by my insurance company, as the law provides my insurer the right to consent a claim under my policy. Any release made in good faith, prior to receipt of revocation, shall be deemed valid. This release of information must be filled out completely, signed and dated. A photocopy and/or facsimile of this authorization may be treated in the same manner as the original; however, LMHC reserves the right to require an original consent. I understand the protected health information used or disclosed per this authorization may be subject to re-disclosure by the recipient and may no longer be protected. I will receive a copy of this signed form upon request.

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE
 UNLESS OTHERWISE INDICATED BELOW:
 _____ Do NOT release alcohol or drug treatment records protected under federal law.